



Certification Number

## Home Health Services Notification Cover Sheet

\* Provider Name/NPI

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\* Member Name and ID#

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\* Certification Dates

\* From

\* To

Submitter's Phone #

\* Date Notice Completed

\* Submitter's FAX #

### \* TYPE OF NOTIFICATION

☐ Start of Care Notice      ☐ Recertification Notice      ☐ Additional Service Notice

☐ Additional Unit Notice      ☐ Supporting Documentation      Discharge Date

### COMPLETED DOCUMENTATION

☐ Plan of Care Attached

☐ Addendum Sheet (if applicable)

Score of LOCUS

Date of Face to Face

Date of LOCUS

### SERVICES TO BE UTILIZED

	Proc. Code.	Modifier	Units
Nursing	<input type="text"/>	<input type="text"/>	<input type="text"/>
PT	<input type="text"/>	<input type="text"/>	<input type="text"/>
OT	<input type="text"/>	<input type="text"/>	<input type="text"/>
SLP	<input type="text"/>	<input type="text"/>	<input type="text"/>
Psychotropic Meds	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Health Aide	<input type="text"/>	<input type="text"/>	<input type="text"/>
MSW	<input type="text"/>	<input type="text"/>	<input type="text"/>

### COMMENTS

FAX to 1-866-598-3963 or Submit through the Portal

\* Required fields – Form will be returned if not completed.